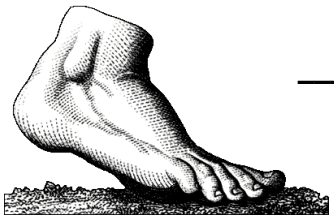

BAY AREA FOOT & ANKLE ASSOCIATES

JOHN W. SCIVALLY, D.P.M.

WELCOME

PATIENT INFO:

First Name: _____ M.I. ____ Last Name: _____

Patient Email:_____

Address: _____ City: _____ State: _____

Zip Code: _____ Hm Ph: _(____)_____Wk Ph _(____)_____

Age: _____ D.O.B.: _____/_____/_____ Sex: M F SSN: _____-_____-_____

Driver's License: _____ State: _____ Spouse's Name: _____

Referred by: _____ Primary Physician: _____

Is your visit today a Worker's Comp Claim: Y N Auto Accident: Y N

Best number to reach you to inform you of lab results, appt. changes, etc?

Hm # Wk # Cell #: (____)_____

EMPLOYMENT INFO:

Occupation: _____ Employer: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _(____)_____

EMERGENCY INFO:

Name of person to contact: _____Ph: _(____)_____

Address:_____City:_____ State:____

Zip: _____ Relation: _____ Wk Ph: _(____)_____

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(925) 937-2860

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(925) 932-3663

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Brentwood, CA 94513
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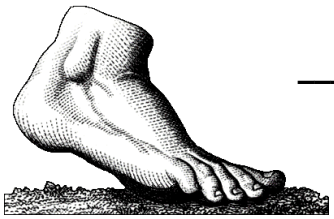

BAY AREA FOOT & ANKLE ASSOCIATES

JOHN W. SCIVALLY, D.P.M.

IMPORTANT INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate or suspend my care and treatment, all fees for professional services rendered me will be due and payable immediately. In the event of default, I promise to pay legal interest on the indebtedness together with any such collection costs and reasonable attorney fees that may be required to effect collection of the balance due. Payment for services rendered and/or co-payment are due at time of service unless special arrangements are made with the billing department. Any payment and/or co-payment not received at time of service will be assessed a $10.00 service charge. For any credit card transaction of $15.00 or less, there will be a $2.00 service charge.
There are thousands of insurance plans and the companies are constantly changing their coverage. It is your responsibility to know exactly what procedures, visits, medications and labs your plan covers. Read your insurance information carefully and call the company if you have any questions. Any time that you have a change of your mailing address or insurance, you must inform this office so that we can update your chart. If we must re-bill because of incorrect insurance and/or address information, there will be a $10.00 service charge. We accept you as a patient with the understanding that you know your coverage and benefits. In the event that your insurance denies a claim, payment for that/those date(s) of service is/are due immediately upon receipt of a statement. I authorize Dr. John W. Scivally, D.P.M. to release any information required to process my claim(s). I also authorize the release of my records to other medical professionals for the purpose of treatment. Dr. John W. Scivally agrees to accept the charge determination of the insurance carrier as the full charge and the patient is responsible only for the deductible, co-insurance, co-payment and any non-covered services. Co-payments, co-insurance and deductibles are based upon the charge determination of the insurance carrier.

- ***I have read and agree with the above financial disclosures and hereby authorize Dr. Scivally to examine and treat me and/or my minor child as deemed necessary.***

PATIENT'S SIGNATURE:X_____DATE / /

GUARDIAN'S SIGNATURE:X_____

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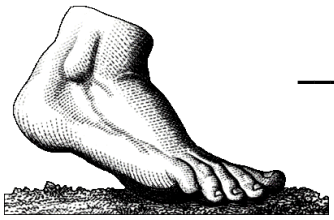

BAY AREA FOOT & ANKLE ASSOCIATES

JOHN W. SCIVALLY, D.P.M.

No Show and Cancellation Policies

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient visit. Since appointments with Bay Area Foot and Ankle Associates and Dr.John Scivally are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs and to contain our fees, we maintain a No Show/Cancellation Policy for all our patients. To promote efficient access to our office, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations must be made between 8:30am and 5:00pm on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the phone by speaking to one of our scheduling staff. Patients will not be charged for an office visit if a cancellation is made 24 business hours before their appointment.

In the event that an appointment is missed or cancelled with less than 24 hour's notice or no notice, a $50 charge will be billed. If a second no-show or same day cancellation occurs, we reserve the right to terminate the patient-doctor relationship.

This policy is in effect for all appointments at our office, including orthotic castings and orthotic dispensals. Again, all no-shows or same day cancellations will be billed $50 if not cancelled with a 24 business hour notification.

Finally, you acknowledge that you have had the opportunity to review this agreement with the counsel of your choosing. This agreement shall be valid and enforceable for five years from Bay Area Foot and Ankle Associates last day of service to you. Bay Area Foot and Ankle Associates and Dr. John Scivally reserve the right to modify any policies without notice.

My Signature below indicates that I have read and understand these policies.

*X*_____ _____

Patient or Responsible Party Signature *Date*

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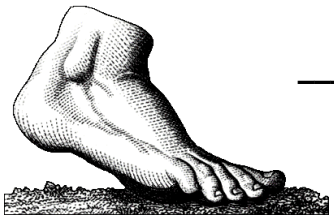

BAY AREA FOOT & ANKLE ASSOCIATES

JOHN W. SCIVALLY, D.P.M.

AKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the notice of privacy practices and that I have read (or had the opportunity to read if I choose) and understood the notice.

_____ _____

Patient Name(Please Print) *Date*

_____

Patient or Authorized Representative

_____

Signature

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